2011 Wyoming Telehealth Consortium Report



James F. Bush, M.D., F.A.C.P., Chairman Telehealth Consortium Wyoming Department of Health March 31, 2011 James.Bush@health.wyo.gov

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Overview

The Consortium is the appropriate coordinating body for Telehealth. It facilitates that both contracts involving the state and those not involving the state have a degree of integration and cooperation.

- The Consortium is a statutorily established body for cooperation and standards. The Consortium has made progress in building cooperation and establishing standards for Telehealth.
- The majority of Telehealth networks operating in Wyoming are already members of the Consortium.
- The Consortium holds the vision and plans for increasing clinical services statewide.



- Slow but steady progress has been made in Telehealth through concerted efforts of many parties, on a limited budget. Cooperation is increasing.
- Clinical services are expanding and are the Consortium's current priority.
- The Consortium is already providing limited technical services to network participants.
- The Consortium has established relationships with out-of-state networks, in-state regulatory agencies, professional associations, the Video Task Force, and state agencies.

Background

There has long been recognition of the need and potential for telehealth within Wyoming, but earlier attempts to produce a coordinated statewide clinical system had failed. In states with medical schools where there is a concentration of both information technology experts as well as clinical experts in adequate numbers to provide coverage, the school typically becomes the organizing center for telehealth. Universities without medical schools have not had the clinical expertise to successfully produce telemedicine networks. Hospitals generally produce closed systems which significantly limit functionality and use of the system, as only those providers who are already using that hospital enroll in the system. Several hospitals bordering our state had already reached into Wyoming and established originating sites, such as between Billings, Montana, and Sheridan and Cody, Wyoming, but these are usually between a single clinic, such as oncology and the group's main office. There were scattered units in various clinics doing sporadic telehealth visits, but these were all almost exclusively between fixed sites, where a physician or psychologist would be providing service at a branch office.

Within Wyoming, the Southeast Wyoming Telehealth Network (SEWTN) was an attempt to link the hospitals in southeastern Wyoming and southwestern Nebraska, but it lacked statewide spread. In Casper, a

grant was given to pilot a telestroke program based on a program called "Reach," but it was limited to a single site and was not self-sustaining financially. The University of Wyoming, aided by Wyoming Department of Health (WDH) grants, built a program over four years called "WYNETTE," but it had no clinical activity. It had become clear that no single agency was stepping forward to coordinate efforts and direct State resources and, as a result, the State was developing a "Balkanized" system of telehealth dependent on out-of-state systems.

Dr. Brent Sherard felt that Wyoming needed a statewide system that could provide the three main areas of clinical medicine: 1) education, 2) clinic visits, and 3) emergency medicine. Dr. Sherard asked me to explore the options for bringing together the interested parties, and developing standards and a viable clinical system. It had to be simple to use, and eliminate the need to involve information technology (IT) personnel on a routine basis. The WDH formed a Consortium involving hospitals, clinicians, State agencies, including the Office of Chief Information Officer (OCIO) and Department of Corrections (DOC), the Wyoming Health Information Organization (WyHIO), and service providers. With a \$100,000 grant to the Wyoming Hospital Association (WHA), the Consortium established a grant that was applied for by all but two hospitals within the state to procure video conferencing equipment. Each hospital was then connected by a bridge supplied by Cheyenne Regional Medical Center (CRMC) and educational conferences are now available to hospitals statewide.

To proceed to the next level of clinical medicine, it was understood that a more sustainable model would be required as well as establishing statutory authority. This was addressed in the 2009 Legislative General Session when House Bill 81 was passed and signed by the Governor.

Statutory Authority

The language of the Telehealth Consortium Bill spells out the purpose, membership, and authority of the Telehealth Consortium and reflects the will of the Governor and the Legislature that Wyoming would create public-private collaboration while avoiding redundancies. The full bill is attached, but the key points are as follows:

- The WDH shall form a Consortium to include the OCIO, State agencies, and private health
 organizations to facilitate the operations of a statewide interoperable system, using existing
 infrastructure as possible.
- Its members will be appointed by the Director of the WDH and shall include the OCIO's representative.
- The Consortium will:
 - Coordinate the development and promotion of statewide standards for an interoperable telemedicine/telehealth network and, where applicable, promote definitions and standards for statewide electronic health transactions;
 - Promote conformance of compliance with all privacy and security laws;
 - O Seek funds for operations and to enter into contracts;

- Implement, promote, and facilitate the voluntary exchange of health information between individual, entities, and agencies that are providing services paid for by Medicaid in conformity with OCIO rules; and
- Promote a network among State agencies, in collaboration with the OCIO.

Membership

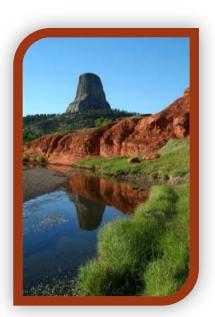
The Director of the Department of Health appointed the initial members of the Consortium; a list of current members is attached to this report. Members currently include the Wyoming Department of Health, Wyoming Department of Corrections, the University of Wyoming, payers, State Legislators, hospital representatives, Telecom providers, physicians, the Board of Medicine, the Wyoming Medical Society, the Wyoming Hospital Association, Veteran Affairs, Indian Health Service, and the Governor's Office. For administrative support it was felt most appropriate to use the WyHIO, rather than contract with any one hospital, as they had the ability to subcontract technical support.

Accomplishments

The Consortium meets on a monthly basis and can be attended either in person, via conference call, or over the Internet via Live Meeting. Progress has been made in the educational goals, infrastructure improvement, policy modifications, and clinical applications.

Education: Continuing Medical Education (CME) and Continuing Educational Units (CEU) are currently available statewide, being offered through Cheyenne Regional Medical Center, Wyoming Medical Center, Utah Telehealth Network, and Denver Children's Hospital. Over 7,000 minutes per month are being used. All but two hospitals are currently connected. Emergency Medical Technician certification classes were held over the network. The annual TA Ranch Educational Symposium on Mental Health recently concluded and was attended by hundreds of participants over the entire state (see attached educational committee report).

A greater emphasis is being placed on outreach to the providers within the State to make them aware of the availability of telehealth. An educational video showing the benefits of telehealth and how to use the statewide system will be produced and distributed to every provider, hospital, and skilled nursing facility followed by outreach into their community.



Infrastructure: A recent FCC/OHRP grant administered by the University of Wyoming has increased the T1 capacity of several Mental Health sites within Wyoming. Don Jackson of TCT West has been updating the Consortium on the infrastructure capacity of the state, and the OCIO has been closely following. At this time, there is adequate capacity in the majority of the state for current telehealth needs. Future growth will demand increased capacity and that need is being coordinated with the Governor's Video Task Force (VTF) project and the joint OCIO and Wyoming Business Council project on Broadband Planning and Mapping.

Standard Setting: As required by statute, the Consortium's IT subcommittee has established basic technical Standards (attached),

and also established a means of interoperability testing (attached). These have been approved by the Committee of the Whole, and forwarded to the OCIO for review and Rules promulgation.

Regulatory input: Medicaid policy was initially modified to allow for payment of telehealth, mirroring Medicare regulations. Through the Consortium, we approached Blue Cross and Blue Shield and Cigna who also have implemented payments for telehealth. After identifying the State licensure process as a barrier to provision of services, we worked very closely with the Wyoming Board of Medicine to streamline their policies, facilitating rapid licensure while retaining protection for the citizens of Wyoming. The Board of Medicine is very involved with the Consortium meetings. We have also identified hospital credentialing as a barrier, and as soon as CMS publishes their new rules regarding Hospital Credentialing for Telehealth (expected the first week in April), the Wyoming Hospital Association has agreed to sit down with me to review them and work to update hospital credentialing under the new rules.

Clinical: Clinical applications are showing the most rapid growth. The facilitation of the Consortium has been instrumental as Prison Health Services, Avera Healthcare from South Dakota, Denver Children's Hospital, and the University of Washington have initiated clinical programs within the state, and we made sure they are aware of and compliant with the standards set above. Also, the successful adoption of the CMA system (a desktop telehealth system) by the Consortium is allowing us to connect physicians and facilities at very low cost. I shall now go into greater detail on each of these projects.

Current Projects in Wyoming

Prison Health Services (PHS): Under contract with the Wyoming Department of Corrections, Prison Health Services has been on the leading edge of adopting telehealth through the prison system in Wyoming. They have their Medical Director seeing patients throughout their prisons, as well as providing mental health services. In addition, through their connections to the Consortium, subspecialists are becoming available. They are on track to have about 2,000 telehealth visits this year.

Avera Telehealth: The Avera system, based in Sioux Falls, South Dakota, is installing telehealth equipment, connectivity, and clinical services in Gillette and Douglas hospitals. This is being funded through grants made by the Helmsley Charitable trust, which invested over \$2 million in each of those hospitals. The Helmsley Foundation wishes to make more grants to other Wyoming hospitals this year and in future years. Avera presents monthly reports to the Consortium and are very willing to make sure their system integrates with our other providers and locations.

University of Washington: Wyoming has only six child/adolescent psychiatrists practicing within the state, and there was a real problem with 66 percent of our Primary Care Providers (PCP's) saying they felt there was inadequate access to mental health care for their patients. (Please see attached report.)

Further, children were being admitted to Psychiatric Residential Treatment Facilities (PRTF's) and Residential Treatment Centers (RTC's) through the Multidisciplinary Team Process (MDT's) without any evaluation by a physician just to get an evaluation by a psychiatrist. This was contrary to the Centers for Medicaid and Medicare Services (CMS) policy, and was clinically inappropriate and financially wasteful. The WDH had also identified that drug utilization in the psychotropic categories was exceeding 39 percent of our entire pharmacy budget, and many children were exceeding basic parameters established by our Pharmacy and Therapeutics Committee. After presenting this data to Governor Freudenthal, the WDH entered into contracts with the University of Washington, which functions as Wyoming's Medical School, to provide services via telehealth. These include telephonic consultation with any provider in Wyoming

regarding any child or person with a Developmental Disability. Also, they provide a telehealth evaluation of any child prior to a MDT hearing, with a formal report for the panel. A telehealth consult for any Medicaid client can be done at the request of the provider. Finally, a mandatory second opinion is requested for those cases where there was any concern on the part of the Office of Pharmacy Services or if a provider exceeds the parameters on psychotropics set by the Pharmacy and Therapeutics Committee. These contracts were finalized the last week of December and services began in January. The feedback from our providers has been very positive. This program is funded by Medicaid and the Mental Health and Substance Abuse Services Division.

Wyoming Telepsychiatry Project (WTPP): Another identified group, involving a great deal of State resources, is our Title 25 clients. The WDH entered into a contract for a pilot study with Dr. Richards to see if a system could be developed that would facilitate evaluation of adults by telehealth and prevent the cycle of admissions to the Wyoming State Hospital, followed by inadequate outpatient follow-up, which leads to repeat episodes of unstable behavior and trips back to the emergency room, where the cycle repeats.

Denver Children's Hospital (DCH): DCH has been a regular attendee of the Consortium meetings and coordinates activities through the Consortium. Dr. Manchester of DCH is starting to perform his genetic consults via telehealth. The first clinic will originate in Lusk, Wyoming. As we work through the details of this, other specialists from Denver Children's Hospital will be available to the Primary Care Providers of Wyoming. Contact has been made for diabetes clinics to be the next clinical area of interest.

The CMA system: This is an exciting new technology that brings telemedicine into the reach of every clinic and nursing facility in Wyoming. It allows desktop units to be able to connect in a secure, HIPAA compliant manner with other desktops and also with the videoconferencing systems already present in the hospitals and mental health clinics within the state. This was tested initially by the cardiologists here in Cheyenne, and also by Dr. Bartholomew in Saratoga, Wyoming, who successfully had a wound care consult on his nursing home patients. Psychiatric consults are currently being arranged with the Wyoming State Hospital. We have also just installed the software with Dr. Wohl and did a preliminary test from his office in Sheridan, Wyoming. Next we hope to install the software with two more physicians in Douglas, Wyoming, and one in Pinedale, Wyoming. We are developing a video that outlines the benefits of telehealth and also demonstrates the ease of use of this system. Along with the video, we are planning a tour to the physicians and nursing facilities around the state to educate them on telehealth benefits and acquaint them with the CMA product.

The Consortium, through funds made available by the WDH, is making CMA licenses and HD desktop cameras available at no cost to the first 50 providers to achieve a critical mass of users. If further licenses are required, they can be attained at a cost of \$20,000 for 300 additional licenses. As part of this project, we are building a directory of providers, with connections available with a click on their name.

Future Goals

The immediate goal of the Consortium is to increase education to our providers about the CMA system and to install it for as many who are willing to use it.



We will build the directory of users with their internet (IP) addresses.

We want to focus on our nursing facilities in particular, to promote use of telehealth, especially to eliminate use of ambulance to transport patients to emergency rooms. This way we prevent two ambulance trips and an emergency department visit to a physician who doesn't know the patient. The local nursing facility nurse will be in the room with the patient and be able to answer the doctor's questions, resulting in the patient being more rapidly and comfortably treated while reducing unnecessary testing.

We are also looking into emergency telehealth, now that the infrastructure and regulatory issues have been addressed, such as treatment of strokes, heart attacks and trauma. Experience by the Wyoming Medical Center in Casper shows the system must be flexible enough to be used in any emergent situation, inexpensive enough to be worthwhile to the facility, and simple enough to be used by non-technical medical personnel. Once the CMA is in place with most of our providers, we plan then to connect the equipment in all emergency rooms in the state. We hope this can be completed by early 2012.

Projected Needs

As usage increases, there may be a need for more updated bridging capacity. This would be identified in time to be inserted into a budget request. It is anticipated to be in the range of \$300,000. A more definite quote would depend on when the need is required, which depends upon growth of use in the system.

If enough people adopt the CMA system, there might be a need to purchase additional licenses. This currently would cost \$20,000 for 300 licenses. Monthly service charges are \$30.

As clinical usage increases, the existing infrastructure may no longer prove adequate for future needs. We plan to monitor this closely with the OCIO, so whenever new capacity in any State system is called for, we will report the needs of telehealth.

We continue to work with the Video Task Force, and Robert Aylward attends our meetings to be sure communication is flowing bilaterally.

As the OHRP grant concludes, the source of funding for one of the staff disappears, and will need to be replaced or risk losing service capacity. This grant funds the position to administer the FCC grant.

Often there are grants made available that require matching funds, and no resources have been available to apply for several of these grants due to lack of matching funds.